

# R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-028694

FILED VS AUG 31 1959

Registration District No. 728 Primary Registration District No. 2000 Registrar's No. 902

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo'</b> b. COUNTY <b>Greene</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Length of stay in lb <b>40yrs.</b>		c. CITY OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Handley Mem'</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>528 N. Weaver St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>ALLEN</b> Last				4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1959</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec' 15-85</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 1 YEAR Hours	IF UNDER 24 HR Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (City and state or country) <b>Nashville Tenn'</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Albert Allen</b>			13b. MOTHER'S MAIDEN NAME <b>Delia Brooks</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>Madge Rutledge 528 N Weaver St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Ca. of Rt. Lung &amp; Metastasis</b>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <b>5/15/59</b> to <b>8/24/59</b> and last saw him alive on <b>8/24/59</b> Death occurred at <b>II:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Lyman D. Brown M.D.</b>				22b. ADDRESS <b>311 1/2 College - Springfield Mo</b>				22c. DATE SIGNED <b>8/25/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug' 29 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		23d. LOCATION (City, town, or county) <b>Springfield</b>		STATE <b>Mo'</b>		
24. FUNERAL DIRECTOR ADDRESS <b>H.V. Smith 602 N Jefferson St. Springfield Mo</b>			25. DATE RECD. BY LOCAL REG. <b>8-28-59</b>		26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Herbert V. Smith

Licensed Embalmer No. 4289

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.